MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Friday, April 23, 2004
10:13 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
SHEILA P. BURKE
AUTRY O.V. DeBUSK
DAVID F. DURENBERGER
ALLEN FEEZOR
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
CAROL RAPHAEL
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY E. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

AGENDA ITEM:

Public Comment

MR. HACKBARTH: So we are now to the public comment period and we will briefly accept comments.

With all the usual ground rules, which you should know very well by now.

* MR. FENNINGER: I do indeed. And I've been told before that if I'm the only one up here I still don't get all the time.

Randy Fenninger. I represent the American Surgical Hospital Association, which is the trade organization for about 60 of the 100 or so specialty or surgical hospitals which have been identified. We appreciate the opportunity we have had so far to meet with the staff and are delighted that they will be making a site visit or site visits.

I would note that each of your will receive, if you have not yet received, an invitation to visit a hospital as close to your home as we can possibly find to give you the opportunity to see what a specialty hospital is and is not, because they are designed to do certain things and they are not designed to do other things.

I think we all know what a community hospital, is either professionally or personally. We hope you will take advantage of the opportunity that will be provided over the coming months to learn more by such a site visit either with some of your staff or independently.

I would just add a couple of cautions. I actually think the design of the study, the way it was laid out, is very good, it's very thorough and queues closely to what Congress said.

I'm a little bit concerned, having heard this morning's conversation and discussion about measuring revenues and costs and impact, how you're going to compare what may or may not be happening to community hospital revenue and finances, given the difficulties you have already defined in your previous discussions of measuring that exact element. And yet that's quite key, I think, to the overall debate that is going on.

So I guess we'll just all have to live with two-year-old data in whatever you find because I don't think you'll fix the one prior to the other.

A couple of things. First of all, I would urge all of you to take a very open mind into this debate and discussion. I think you pride yourselves on doing that and I can only encourage you to continue to do that as this goes forward. This has been contentious and emotional, as you will know, in Congress and in communities where these hospitals are under development or have been developed. And good analysis is an extremely short supply. We're very hopeful that we get more good analysis coming out of this particular effort.

We would suggest you take a very careful look at why these hospitals grow up. Why are they developed? They are very unique to the community setting in which they occur, whether that's Durango, Colorado; Kalispell, Montana; Modesto, California or

some other city, Milwaukee, Wisconsin which I refer to as ground zero of this whole debate.

But I think it's important that as you go through your analysis that you understand the rationale in those committees because they are different. And the different kinds of hospitals are different. We represent primarily hospitals that perform elective surgery for patients who are otherwise healthy, be they Medicare or non-Medicare. You will find perhaps cardiovascular hospitals having a somewhat different structure, a different model, a different in the community.

So just as you have commented in the past on ASCs, they all don't look alike, they all don't function alike, there are differences. And those will be important, I think, to your consideration. And I urge you to take cognizance of that, as well.

As you go through this, it might be interesting as a sidelight to examine some of the tactics that are being used in communities where these hospitals are either consideration or under development. As you do this analysis at the staff level, I cite economic credentialing and exclusive contracting as two issues that you might find interesting.

On the timeliness of data, the earlier discussion, I want to volunteer our association and our members to be the first to say you want it in a week, we'll get it to you in a week. What can we do to help? We think we're efficient and we think we could probably provide that information to you far more quickly than it's currently coming out, if that's at all helpful.

Let me close by saying it will be difficult I think, and I think your staff has told you this, it is going to be difficult to answer all of the questions with a great deal of depth partly because of data limitations in the Medicare data about our members and the communities in which they operate.

We hope you will not use that as a reason for encouraging Congress to extend the moratorium. We know that we are the new kids on the block. We know that much of the data that you will be looking for is not going to be readily available. We don't think that's a reason to continue to aid and abet monopolization by one set of providers in many communities. And we hope you will consider that as you go forward and reach your conclusions for your final report.

Thank you.

MS. THOMPSON: Hi, I'm Ashley Thompson with the American Heart Association. And I just wanted to commend the commissioners for their discussion on the data needs and the need for more for timely data.

Our organization absolutely shares the same desire in this respect, and we've been working with the hospital field in order to provide more timely data through avenues such as NHIS and Databank, which have been listed. And we do know that those have some limitations.

What we wanted to share with you is, as you continue this very important discussion, we share Mr. Muller's concerns about jumping thoroughly into using the Medicare Cost Report and requiring a timely or a more timely turnaround of that document

as it does contain some data that is difficult to obtain. We just want to look at that more thoroughly.

However, the idea of using Schedule G as an avenue to get at more timely information is something that we would like to look at with you. So we do want to offer our help and assistance as you move forward in this area.

Thanks.

MR. HACKBARTH: Okay, thank you. We're adjourned.

[Whereupon, at 12:17 p.m., the meeting was adjourned.]